PSYCHIATRIC HOSPITAL SERVICES PAYMENT SYSTEM

*payment***basics**

Revised:
September 2006

Medicare beneficiaries with mental illnesses or alcohol and drug-related problems may be treated in specialty inpatient psychiatric facilities (IPFs), either freestanding hospitals or specialized hospital-based units. These hospitals generally furnish short-term acute care. To be admitted to an IPF, patients generally have to be considered a risk to themselves or others.[1] Medicare payments to psychiatric facilities are estimated to be $4.1 billion in 2005. Medicare beneficiaries account for about 30 percent of psychiatric facilities' revenue. In 2002, about 300,000 Medicare beneficiaries had 483,000 discharges from IPFs for a psychiatric or substance abuse disorder, and about 1,800 facilities were Medicare certified.

Until January 2005, Medicare paid IPFs (under the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA) for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually. As of January 2005, IPFs are paid predetermined per-diem rates based primarily on the patient's condition, facility characteristics, and area wages.

Patients are assigned to one of 15 case-mix categories—such as psychoses, depressive neurosis, or personality disorders—containing patients with similar psychiatric problems that are expected to require similar amounts of resources. Patients' per diem payments are adjusted by patient and facility characteristics. Patient characteristics include diagnoses, age, comorbidities, electro-convulsive treatment (ECT), and length of stay. Facility characteristics include location, having a fully functional emergency department, and teaching status. Payment rates also are increased for hospitals located in Alaska and Hawaii and for cases that are extraordinarily costly.

As is the case for stays in short-term acute care hospitals, beneficiaries treated in IPFs are responsible for a deductible—$952 in 2006—for the first admission during a spell of illness, and for a copayment—$238 per day—for the 61st through 90th days. Beneficiaries treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness, with a 60-day lifetime reserve.[2] Over their lifetimes, however, beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.

Setting the payment rates

The prospective payment system (PPS) adjusts per diem payments by:

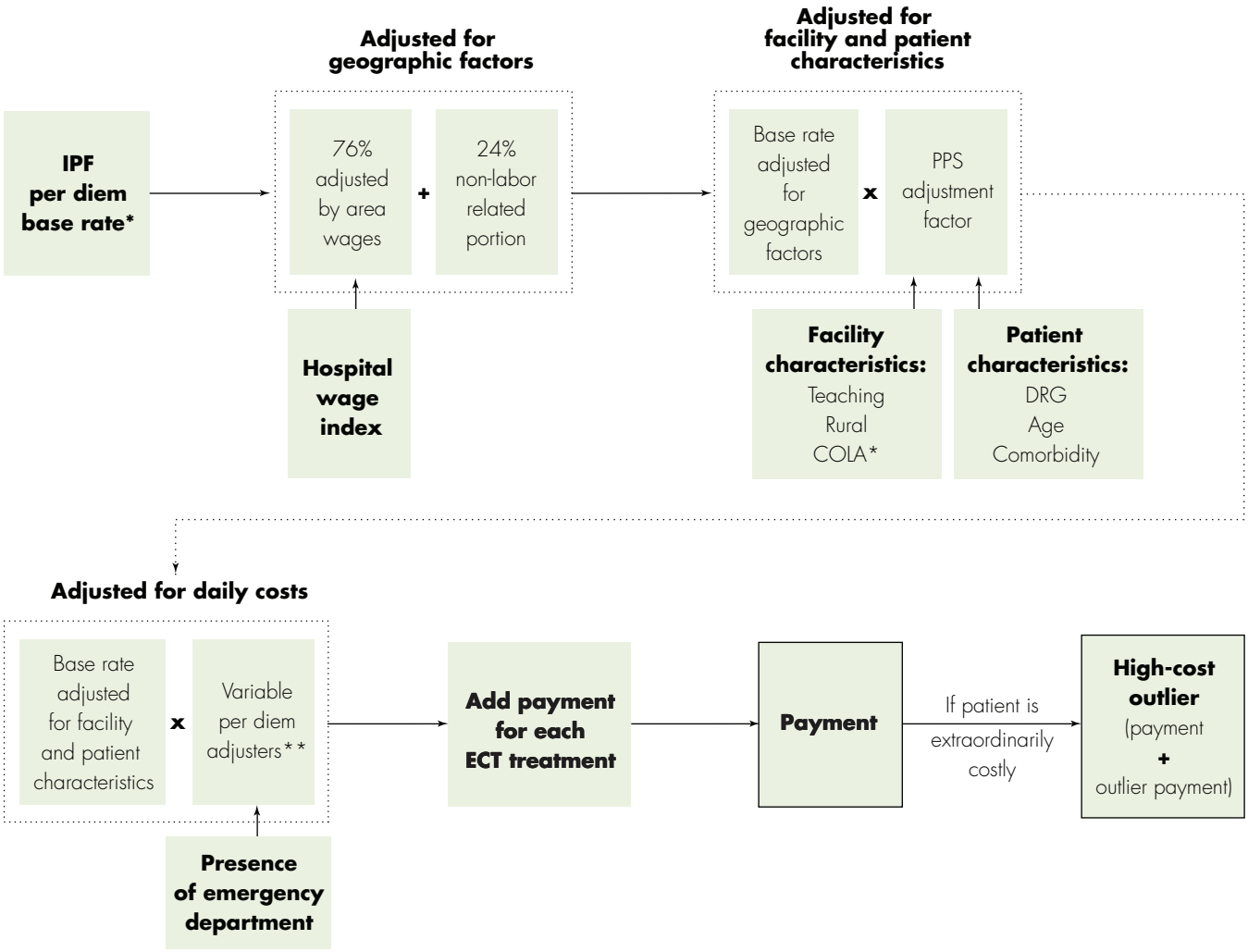
- **patient characteristics**, such as age, diagnosis related group (DRG), 17 specified comorbidity categories, and the number of ECT treatments (Figure 1),
- **facility characteristics**—the IPF's wage index will be applied to the labor-related share (76 percent) of the per diem payment. IPFs in rural areas are paid 17 percent more than urban IPFs, and teaching hospitals have an adjustment based on the ratio of interns and residents to average daily census. Patients treated in IPFs with an emergency department are paid 12 percent more for the first day of the stay, and
- **the base per diem payment** ($595) is higher for the earlier days of each patient's stay to account for the higher costs of caring for patients during those earlier days (Table 1).

The IPF PPS has an outlier policy for cases that have extraordinarily high costs, drawn from an outlier pool of 2 percent of payments. IPFs are reimbursed for costs above a threshold ($6,200 adjusted for wage index, rural location, and teaching)

This document does not reflect proposed legislation or regulatory actions.

MEDPAC
601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Psychiatric hospital services prospective payment system



Note: IPF (inpatient psychiatric facility), PPS (prospective payment system), COLA (cost of living adjustment), DRG (diagnosis related group), ECT (electro-convulsive therapy).
*A COLA adjustment to the non-labor related portion is made for facilities in Alaska and Hawaii.
**The variable per diem adjuster is higher for the 1st day when an emergency department is present. The adjuster declines from 1.31 with an emergency department and 1.19 without an emergency department to 0.92 over time. Table 1 shows the adjuster.

plus the payment for the case. Medicare will cover 80 percent of the costs above the threshold plus the estimated rate for days 1 through 8, and 60 percent of the excess costs for the remaining days. The different risk-sharing rates are intended to counteract the financial incentives to keep outlier cases longer than necessary.

Patients who are readmitted to the IPF within three days of discharge are considered to have an interrupted stay, and the IPF is paid for one admission.

IPFs are paid under the PPS according to their cost reporting year and transition into the PPS beginning in 2005. The transition to 100 percent PPS rates will be complete in 2008. During the transition, a stop-loss policy will be in effect; IPFs will not be paid less than 70 percent of what they would have been paid under TEFRA. The stop-loss policy is intended to protect IPFs and therefore, beneficiaries' access to inpatient psychiatric care.

Table 1 The adjusted rate for IPFs is increased for earlier days of the patient's stay

Day of patient's stay		Per diem adjustment
1	Facility:	
	with a full-service emergency department	1.31
	without a full-service emergency department	1.19
2		1.12
3		1.08
4		1.05
5		1.04
6		1.02
7		1.01
8		1.01
9		1.00
10		1.00

Note: IPF (inpatient psychiatric facility). The per diem adjustment is applied to the rate that is already adjusted for geographic, facility, and patient characteristics. Rates are decreased after the tenth day.

No IPF can opt to be paid at 100 percent PPS rates before the transition is complete because the Centers for Medicare & Medicaid Services (CMS) estimates that the number of IPFs opting for 100 percent would, under budget neutrality, reduce the base rate too much. Payments under the new PPS will be budget neutral with what IPFs would have been paid under the previous payment system.

CMS plans to update the IPF payment rates annually according to the RPL market basket plus capital, used for rehabilitation and psychiatric facilities and for long-term care hospitals. ■

1 Beneficiaries are also treated for psychiatric or alcohol and drug-related conditions in regular beds in acute care hospitals; in these instances providers are paid under the acute care inpatient prospective payment system (PPS).

2 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$476 per day in 2006.